CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPI	ETED
		151303	A. BUII			06/01/2	011
		10.000	B. WIN			00/01/-	
NAME OF P	PROVIDER OR SUPPLIEF	3		1	ADDRESS, CITY, STATE, ZIP CODE		
				301 HE	NRY ST		
ST VINC	ENT JENNINGS H	OSPITAL INC		NORTH	I VERNON, IN47265		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	\neg	ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	REGUESTI OTT OT		+	0			2.112
S0000							
		a			The all constants and a second contract		
	This visit was fo	or a State licensure survey.	S0	000	Thank you for the opportunit		
					be one of the first facilities to		
	Facility #: 0051	08			the online submission proces	SS.	
	Survey Dates: 05-31-11/06-01-11						
	Survey Dates: 0	3-31-11/00-01-11					
	Surveyors:						
	Billie Jo Fritch,	RN, BSN, MBA					
	Public Health No						
	T done Health IV	arse Surveyor					
		D. I.					
	Jennifer Hembre	·					
	Public Health No	urse Surveyor					
	Ken Zeigler						
	Laboratorian						
	Laboratorian						
	QA: claughlin 0	06/06/11					
00406	410 IAC 15-1.4-2((a)(1)	ł				
S0406	410 IAC 15-1.4-2((a)(1)					
	(a) The hospital sl	hall have an					
	effective, organize						
		uality assessment and					
		gram in which all areas					
	of the hospital par						
		ongoing and have a					
	written plan of imp						
	evaluates, but is r						
	following:						
	(1) All services, in	cluding services					
	furnished by a cor						
	•	ent review and interview,	l so	406	Direct Service of PediatricsT	he	06/14/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151303		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE COMPI 06/01/2	LETED	
	PROVIDER OR SUPPLIEF		301	ET ADDRESS, CITY, STATE, ZIP CODE HENRY ST		
ST VINC	ENT JENNINGS HO	DSPITAL INC	INOR	RTH VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	the facility failed service and four contract were into Quality Assurant Improvement (Q Findings include 1. Review of face 6-1-11 indiccated direct service of contracted service ambulance service mobile cataract service facility QAP 2. Interview with hours confirmed pediatrics and the transcription, ambulancy/linen and laundry/linen and four contracted service facility QAP 2. Interview with hours confirmed pediatrics and the transcription, ambulancy/linen and laundry/linen and four contracted services and the transcription and laundry/linen and four contracted services and the transcription and laundry/linen and four contracted services and the transcription and laundry/linen and four contracted services and the transcription and laundry/linen and laundry/linen and four contracted services and the transcription and laundry/linen	to ensure one (1) direct (4) services provided by cluded in the facility ce and Performance (API) program. citility documents on d lack of evidence that the pediatrics and the ees of transcription, ce, laundry/linen and services were included in I program. h #S3 on 6-1-11 at 1245 the direct services of		deficiency was corrected 6/14/11 with discussion at Quality Council meeting. A pediatric quality indicator form was developed to be in the review of 100% of a pediatric cases. Any pedia cases that do not meet quality indicator form as set forth; they was referred to the appropriate Medical Staff representati further review and follow the action as necessary. The form along with any follow documentation will be subto Quality Review quarter will become part of the maquality spreadsheet and was monitored on an ongoing. The information will also be shared with the Patient Ar Committee, Patient Safety Council, Department Man Meeting, Medical Staff an Board of Directors. The Manager or design be responsible for monitor pediatric quality indicator form on every pediatric case. Transcription Contraservices The deficiency was corrected on 6/14/11 with discussion at the Quality meeting. Quality assurances were sent to St. Vin Jennings Hospital by the lof Transcription at St. Vin Health. The quality assurances will be run on a quality sand sent to the Health formation management department.	the A review utilized III atric ality vill be every final personal be every final be basis. The every final be basis and the every final be basis. The every final be basis and the every final basis an	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOR DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151303	A. BUII B. WIN	LDING	00	COMPL 06/01/2	ETED
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					reminder notice will be sent in Manager of Transcription at Vincent Health prior to quart end on an ongoing basis. Revenue Cycle Operations Manager or designee will be responsible for ensuring the quality assurance scores are received and forwarded on to quality council on a quarterly basis. Ambulance Service The deficiency was corrected on 6/14/11 with discussion at the Quality Council meeting. Refort the ambulance service has been performed on an ongoing basis but have not been reported to the quality council for incluin the master quality spreads Ambulance service has now added to the quality spreads to be shared with the Patient Care Committee, Patient Safety/Quality Council, Department Manager Meeting Medical Staff and the Board Directors. The information has now been made a part of this reporting mechanism and with reported from this point forw. The Emergency Department Nurse Manager or designee will report the ambulance services to quality council. Laundry/Linen ServiceThe deficiency was corrected on 6/14/11 with discussion at the Quality Comeeting. The linen delivery a quality checklist was being completed and turned into the quality review on a quarterly	St. er St. er	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151303		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/01/2011	
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				basis; however, the information was not reported on the qualified patient Area Care Compatient Safety/Quality Council Department Manager Meet Medical Staff and the Boar Directors. The information now been made a part of the reporting mechanism and varied from this point for The Housekeeping Supervalue designee will report the line delivery and quality checkliquality council on an ongoin basis. Mobile Cataract Servalue deficiency was corrected of 6/14/11 with discussion at Quality Council meeting. It determined that per the contractual obligations of SightPath, mobile cataras service, that St. Vincent Je Hospital surgery staff will in SightPaths' ability to provide the items needed to provide cataract surgery. A checklibe provided to surgery staff them to inventory the present equipment as needed to provide cataract services. SightPath has been added quality spreadsheet and with collected and monitored or ongoing basis. The information will then be reported to the Patient Area Care Committed Patient Safety/Quality Council Department Manager Meet Medical Staff and the Boar Directors on an ongoing basis. The Surgery Manager or	ality with mittee, ncil, ing, d of has his vill be ward. isor or en st to ng iceThe n he was ct nnings nonitor e all of e st will f for ence of to the ll be an tion ee, ncil, ing, d of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 151303 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 301 HENRY ST ST VINCENT JENNINGS HOSPITAL INC NORTH VERNON, IN47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE designee will report the checklist to quality council on a quarterly basis. 410 IAC 15-1.5-6 (b)(4) S0932 (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. S0932 The deficiency will be corrected 06/30/2011 Based on document review and staff on 6/30/11 by the completion of interview, the facility failed to develop an mandatory training for all nurses individualized care plan for 1 of 4 on the appropriate way to in-patients. implement care plans in Quest. This training will take place on June 28th and June 30th. Chart Findings include: audits will be done on a monthly basis with reporting to quality 1. Review of patient #N17 medical council quarterly on an ongoing basis. MedSurg Nurse Manager record beginning at 11:30 a.m. on 6/1/11 or designee will be responsible indicated the following: for the chart audits and reporting (A) The patient had only one (1) problem to the quality council. addressed in his/her careplan. The careplan developed indicated the patient required oxygen. (B) The oxygen was discontinued on 5/29/11. Care plan did not reflect oxygen was discontinued.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5P6011

Facility ID: 005108

If continuation sheet

Page 5 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE					
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S0952	medications shall accordance with semedical staff policing in the blood transfusion intravenous medical administered by perphysicians, the perspecial training for in accordance with Based on recordance with Based on recordance with approved policies and peright patients. Findings inclusion. 1. The policy Packed Red Brevised 6/02, revised 6/02, revi	ions and intravenous be administered in tate law and approved ies and procedures. usions and lations are lersonnel other than rsonnel shall have these procedures in subsection (b)(6). ord/policy review rview, the hospital re administration of sions in accordance d medical staff rocedure for six of lide: "Transfusion of Blood Cells", read: complete) are then sminutes x's 2 then intes until blood in	SO	952	This deficiency will be correct on 6/30/11. A policy and procedure revision was completed. Initiation of new to bank documentation form was completed. A mandatory train for all nurses on June 28th a June 30th will be done to eduthe nurses as to the revised policy and new documentation form. An audit of 100% of all blood transfusions will be done a weekly basis with submissiquality council on a quarterly basis. The audits will be completed on an ongoing ba Audit report by the Laborator with any deficiencies documentation will be reported the Nurse Manager or design for follow up corrective action. The corrective action report is be returned to the Laboratory within 10 days of notification the Nurse Manager or design. The Laboratory Supervisor of designee will be responsible maintaining compliance.	blood as ning nd ucate on ne on ion to sis. Ty ed to nee n. shall y of nee. r	06/30/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :		
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	Vital signs ma	ny be taken more					
	often per nurs	sing judgement and					
	patient status. Vital signs are to be recorded on the transfusion						
	record sheet."	•					
	2. In review of	f six patients					
	receiving twel	ve blood units, six					
of these received-units did not							
	have complete	e documentation,					
	per policy, on	the Transfusion					
	Record Sheet	form including:					
	Patient #1						
		inistered on 5/29/11					
		l hour post vitals					
	were documei	nted at 5 minutes.					
	Patient #2						
		inistered on 5/03/11					
	at 1245: Ther						
		documentation for					
	_	st transfusion vitals.					
	ine i noui pos	st ti anglugion vitais.					
	Patient #3						
	Unit #3 adm	ninistered on 4/30/11					
	at 1810: The	1 hour post					
	transfusion vi	_					
	documented a						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
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TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	Patient #6:						
		inistered on 3/18/11					
	at 1515: There	e was no op date/time; there					
		transfusion vital					
	time or vitals						
	Patient #7:						
	Unit #5 adm	ninistered on 3/15/11					
	at 1340: Ther	e was no					
		n of who entered					
	the vital signs transfusion.	for the post					
	transiusion.						
	Patient #8:						
		ninistered on 2/28/11					
	at 1450: Ther						
		n of who entered on stop date and					
	time.	in stop date and					
		at 1:00 p.m., staff					
		acknowledged the					
	above-listed n	_					
	documentatio	n.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
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(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
S1118	410 IAC 15-1.5-8 ((b)(2)					
	safety and well-be assured as follows	all hospital be developed and n a manner that the ing of patients are					
	maintained which hazard to patients	condition shall be created or ned which may result in a to patients, public, or					
	employees.		0.1	S1118 The deficiencies were correc		tod	06/02/2011
		ation, document review	on 6/2/44. Plant Operations has			06/03/2011	
	and interview, th	•			provided the Radiology Mana		
		could result in a hazard			with a checklist and procedur	·e	
	to patients, visito	ors and staff in 2			sheet that is posted beside th	ne	
	instances.				eye wash station in the dark room. Eye wash checklist wil	l be	
	Findings include	:			completed weekly by Radiolo staff. Reporting will be submi to quality council quarterly. T	tted	
	1. While touring	the radiology			Radiology Manager or design		
	•	31-11 at 1310 hours with			will be responsible for the		
	•	S4, it was observed that			ongoing review and monitoring	-	
		ion in the dark room			the department with quarterly submissions to quality	′	
	•	emicals are used lacked			council. Eye wash station for		
	***************************************	f testing the eye wash to			mechanical room water testir		
		properly, thus creating a			area was ordered and installed		
	potential safety h	1 3,			6/3/11. A checklist was poste		
					the eye wash station. A bottle the appropriate solution is	e with	
	•	the facility on 5-31-11 at			marked with the expiration da	_{ate}	
		#S2 and #S13, it was			and is kept by the eye wash	· - -	
		re was no available eye			station. All Plant Operations		
	wash in the area where caustic chemicals				staff were educated on 6/3/1		
are used for water testing, thus creating a			the proper use of the station				
	potential safety hazard.			the solution. A check of the e wash station was added to the			
	3. Review of fac	eility documents on			mechanical room walk throug		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151303		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/01/2011	
	PROVIDER OR SUPPLIER		301 HE	ADDRESS, CITY, STATE, ZIP CODE NRY ST I VERNON, IN47265	
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	5-31-11 indicated lack of evidence of eye wash testing in the radiology dark room. 4. Interviews with #S2 and #S13 on 5-31-11 at 1310 hours and 1330 hours respectively confirmed the lack of documentation of eye wash testing in the radiology department dark room and the lack of an eye wash in the area where water testing is done and that caustic chemicals are used in both areas.			inspection list that is comple daily. The Plant Operations Manager or designee is responsible for submission t quality council quarterly on a ongoing basis.	0
S1162	follows: (2) There shall be equipment and spisafe, effective, and of the available seas follows: (A) All mechanica (pneumatic, electribe on a document schedule of approwith the manufactumaintenance schedule	sufficient ace to assure the d timely provision rvices to patients, I equipment ic, or other) shall ed maintenance priate frequency and urer's recommended dule.	01162	This definion of was corrected	
	staff interview failed to ensur preventative r required rotat (rpm) testing one of five cer	ocument review and v, the laboratory re documentation of maintenance of tions per minute or time checks for atrifuges used in stry (urinalysis), in	S1162	This deficiency was corrected 6/6/11. The Prothrombin Time policy/procedure has been revised to include appropriated RPM and spin times necessed achieve platelet poor plasma acceptable for testing. The found spin times will be check annually by the Laboratory Supervisor or designee on a congoing basis. Documentating annual testing will be maintant.	te ary to a RPM ed on of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151303		A. BUILD	DING	NSTRUCTION 00	l` ′	E SURVEY PLETED /2011	
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	accordance b	etween the approved			in the Laboratory. This de was corrected on 6/6/11.		
	1 ^	rocedures, and		testing of platelet poor plasma		asma per	
	clinical engineering reported.				policy/procedure was completed at 3700 RPM at 15 minutes and		
	Findings included:				plasma. This will be che	yielded appropriate platelet-poor plasma. This will be checked annually by the Laboratory	
	1. The policy	"Prothrombin time			ongoing basis. Docume	ntation of	
	(PT), policy/procedure # COAG 001.02, revised 2/14/07, used for				test results will be maintained in the Laboratory.		
					,		
testing PT values lacked							
	documentation to indicate either						
	1	per minute (rpm) or					
	total spin time	es for this test.					
	2. Review of t	he clinical					
	engineering w	vork order					
	performed on	5/05/11 for the					
	Plasemafuge-	6, serial #61060-16,					
	used to centri	fuge PT specimens,					
	indicated this	centrifuge was					
	checked for 3	700 rpm (actual					
	l '	er 15 minutes					
		nutes). It could not					
		d these values were					
	within accept	able limits.					
	3. On 6/01/11	at 11:00 a.m., staff					
		acknowledged the					
	above-listed n	· ·					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
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S1166	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) documentation. 410 IAC 15-1.5-8(d)(2)(C) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. Based upon document review and staff interview, the laboratory failed to assure blood bank alarm temperature wheels were properly maintained and in working order for three of three quarters between 2010 and 2011. Findings included: 1. The policy "Alarm Testing", file name: 1.235, revised 1/15/07, read:		S1	166	This deficiency was correcte 6/13/11.Blood Bank alarm che placed on a computerized notification schedule for quartesting. Lab Tech will do alarcheck and document quarter an on-going basis. Documentation will be kept be Laboratory. The Laboratory Manager or designee will be responsible for compliance.	neck rterly rm rly on by the	06/13/2011
	Alarm Checks	Year:					
	Requirement	: Perform alarm					
	1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151303		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/01/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 HENRY ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ing to SOP #1.235"		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	2. Quarterly conthe refrigerators storage indicated were to be documentation. It is a summarized part of these summarized per per summarized per p	ertification tests for r used for blood unit ted quarterly checks cumented on 11/12/10 Review of the n indicated: uarterly date due Late 11/12/10 10 days 13/03/10 10 months, 23 days above-listed dates n the quarterly dates olicy. at 10:00 a.m., staff cknowledged the hissing						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 151303		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED 06/01/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 301 HENRY ST NORTH VERNON, IN47265			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		COMPLETION